



## Response to commentary

R. Giacaman<sup>a,\*</sup>, N.M.E. Abu-Rmeileh<sup>a</sup>, A. Hussein<sup>a</sup>, H. Saab<sup>b</sup>, W. Boyce<sup>b</sup>

<sup>a</sup>*Institute of Community and Public Health, Birzeit University, Birzeit, West Bank, Occupied Palestinian Territory*

<sup>b</sup>*Social Program Evaluation Group, Faculties of Education and Health Sciences, Queen's University, Kingston, Ontario, Canada*

We would like to thank Drs Neria and Neugebauer for their commentary<sup>1</sup> as it allows further clarification of matters, and assists in raising issues beyond those contained in the paper, going into what we consider to be at the heart of psychosocial/mental health research and war. It is hoped that their commentary and this reply will contribute to a debate on humiliation and health outcomes, and motivate public health researchers to pay more attention to this important, yet neglected, topic.

The main thrust of our article<sup>2</sup> entails pointing to humiliation as prevalent during war and conflict, and to its association with health outcomes. Humiliation seems to be given insufficient attention by the Anglo-Saxon public health literature on conflict-affected zones, perhaps because humiliation is a construct that has diverse meanings and significance to identity and self-worth in different cultures. We understand the particular conceptualization cited by Neria and Neugebauer,<sup>3</sup> but we also question how humiliation (a feeling or internal experience) could ever be rated independently of the study participant's own assessment. The use of inter-rater reliability<sup>3</sup> is worrisome, given that 'levels of loss, humiliation, entrapment, and danger were rated contextually using a five-point

scale', taking into account descriptive information provided in the interview itself, the narrative summary and the tape-recorded interview. However, reports of emotional reactions were ignored. Brown et al.<sup>3</sup> did not explain how separation of the narrative from the emotional reaction is possible, and how this process is viewed as 'objective'. Furthermore, the commentators conceptualize humiliation as a characteristic of an event. Brown et al. used the Stressful Life Events Battery in their study, indicating that humiliation is an event leading to or contributing to a psychological manifestation, and also implying that humiliation is contextual and cannot be standardized, especially in the Occupied Palestinian Territory where the political context is overwhelming, leaving little room for subtleties in humiliation experiences. It is important to remember that our study is a population study rather than a clinical study; a point that is likely to clarify the differences between Neria and Neugebauer's approach and our own.

There is no logical reason to believe that life events, and humiliation, cannot be conceptualized as independent variables in their own right. In our paper, humiliation was treated as a predictor, active in a social context. Based on focus group discussions with groups of various ages and social positions, including young people, the concept of feeling humiliated was understood as feelings of debasement associated with the loss of dignity and honour, all part of a whole that is well understood locally. We continue to work to understand this

\*Corresponding author. Box 154, Ramallah, West Bank, Occupied Palestinian Territory. Tel.: +972 2298 8654; fax: +972 2295 1181.

E-mail addresses: [giacaman@alquds.net](mailto:giacaman@alquds.net), [rita@birzeit.edu](mailto:rita@birzeit.edu) (R. Giacaman).

phenomenon, from the bottom upwards, as opposed to borrowing from elsewhere, hoping to contribute to the literature on the violations of conflict, and to interventions aiming to alleviate the social suffering of war.

We utilized a different methodology from that cited by Neria and Neugebauer, as different questions related to a different context were being asked. It is always the case that a method should be determined by the research question asked. Our main questions were: is humiliation, as perceived and understood by people on the ground, associated with health outcomes, and could it be a predictor for health outcomes? Indeed, the complexity of the notion of humiliation and its intricate link to meaning, culture and context alert researchers to the dangers of following 'specific formulas' for definitions and methodologies in all situations. In mental health, what is 'clear' in some cultures may be unclear and with no meaning in another. This is not merely a matter of semantics, or locating the right translation or the right phraseology; it is about a mind-set.

As for validity, our construct was developed in line with findings in focus group discussions locally, as opposed to beginning with an instrument imported from elsewhere, which necessarily requires validation in the local context. Moreover, the Cronbach's alpha for the scale, cited in the paper, revealed reasonable statistical validity. Indeed, the possibility of bias is always there when conducting scientific research. Bias was minimized by dividing the questionnaire into several seemingly unrelated sections, including soliciting the views of young people on love, friendship, satisfaction at school, plans for the future and other such questions. In view of an increasingly conservative local way of life, the questions on love, in particular, are worth further investigation. Understandably, Neria and Neugebauer's views are also biased, as they are coached in the Western way of life and discourse on mental health, which we need to approach carefully, as, once again, in mental health, meaning, culture and context are of the essence.

We take issue with Neria and Neugebauer and caution against linking events to outcome directly following exposure. The claim that only those events occurring before symptom onset should be eligible for analysis is problematic when studying human emotions and behaviour, and assumes an

ability to exclude neurobiological predispositions. The situation is not the same as in dealing with a gunshot wound, or a controlled situation where one can isolate a particular event and freeze all other variables and previous experiences. This point is of particular importance in view of the chronicity of conflict in the Palestinian setting, the repeated exposures to humiliation and the cumulative effects that repeated exposure can bring about, which may or may not be equal to a simple additive total. The notion of threshold beyond which such repeated exposures can induce fundamental behavioural changes is also important, just as the notion of resilience development with repeated exposure over time. Both phenomena have been observed in the Occupied Palestinian Territory and, most certainly, require further investigation.

Our focus is not on psychiatric symptoms and disorders affecting a small proportion of the population. In the Occupied Palestinian Territory, there is a real need to prioritize research endeavours because of the scarcity of available human and financial resources. To date, little research attention has been given to the majority of the Occupied Palestinian Territory population who live between the ease and dis-ease continuum, under chronic stress and with various types of health complaints that cannot (and should not) be classified or diagnosed as disease. Placing a medical label on social suffering can lead to the biomedicalization of this suffering, which does not help and can harm those violated by war. In the Palestinian case, biomedicalization of the social suffering of war also carries the risk of leading to the exclusion out of society (a la Foucault) of the Palestinian narrative on violation and injustice, and its replacement with medications and counselling; one of the unfortunate humanitarian responses to the Palestinians' lot.

## References

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